

Welcome to the
CARE/PASRR training.
Please place yourself on
mute. We will begin in a
moment.

KDADS CARE Program

Level I and Special Admission training for Nursing Facilities.

Presented by Anne Yeakley CARE Program Manager

Questions?

To ask questions during the training, open the chat feature and type in your question. They will be answered as we go.

How to get to the KDADS Website

www.KDADS.KS.Gov/



KDADS PROGRAMS AND SERVICES BY COMMISSION

AGING

- Aging and Disability Resource Center
- Older Americans Act (OAA)
- Senior Care Act (SCA)
- Medicare Programs
 - Senior Health Insurance Counseling for Kansas (SHICK)
 - Senior Medicare Patrol (SMP)
 - Medicare Improvements for Patients and Providers Act (MIPPA)
- Nursing Home Assessment (CARE)
- Respite for Caregivers

BEHAVIORAL HEALTH SERVICES

- Veterans Services
- Behavioral Health Funding Opportunities
- Publications and Reports
- Provider Resource Connection

COMMUNITY SERVICES AND PROGRAMS

- Home and Community Based Services (HCBS)
 - Waiver Integration Information
 - Respite for Caregivers
- HCBS Program Renewal Information
- HCBS Settings Final Rule
- Provider Resource Connection

SURVEY, CERTIFICATION AND CREDENTIALING

- Abuse, Neglect or Exploitation
- Health Occupations Credentialing (HOC)
- Promoting Excellent Alternatives in Kansas Nursing Homes (PEAK)
- Surveys, Reports, Regulations and Statutes
- Adult Care Home Directory and Inspection Reports



The right care, at the right time, in the right place

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SURVEY AND C

- Abuse, Neg
- Health Occ
- Promoting
- Adult Care Reports

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[Adult Care Homes \(SCCC\)](#)

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Select Client Assessment Referral and Evaluation (CARE)

NEWS HIGHLIGHTS



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- Draft Policies for Review / Comment
- Informational Memos
- Final Policies
- Adult Care Homes (SCCH)
- Home and Community Based Services
- Provider Information
- Behavioral Health Services Provider Information
- Client Assessment, Referral and Evaluation (CARE) Provider Information
- Statutes and Regulations
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- Web Application and Survey / Exam
- Center Information and Instructions
- Provider Contacts

CLIENT ASSESSMENT, REFERRAL AND EVALUATION (CARE) INFORMATION

Expand all

- Training
- CARE Brochure
- CARE Manuals
- Kansas CARE Forms
- Kansas CARE Program Annual Report

Nursing Facility CARE FAX Sheet

Click on the document below to enlarge to original size.

Quick Fax Sheet QUESTIONS REGARDING THE CARE PROCESS CALL 785.291.6446			
Type of issue	What to do	Information to send	When
For Medicaid only MS-2126	Fax to KanCare at: 1-866-364-6285 Or mail: The KanCare Clearinghouse: PO Box 3599, Topeka, KS 66661	Fill out completely do not leave items blank. Use the new form MS-2126 Old forms will not be accepted after August 31, 2017	Please send form within 5 working days of the resident Admit. Fill out upon admission and discharge (if discharge will be for more than 30 days.)
Emergency Admissions*	Fax local ADRC and Fax to KDAOS Care: 785-291-3427 or e-mail: KDAOS.CARE@ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Order if applicable 4. APS FORM (PPS 10510) if applicable	Send fax within one business day of admission. 7 days to complete Care Level 1 assessment.
Respite Stay*	Fax KDAOS Care Staff at: 785-291-3427 or e-mail: KDAOS.CARE@ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Respite order signed by Physician include admit and discharge dates	Send fax within one business day of patient admit to KDAOS.
Less than 30 Day Admissions*	Fax to KDAOS Care Staff at: 785-291-3427 or e-mail at KDAOS.CARE@ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Less than 30 day order signed by hospital attending prior to admission*	Send fax within one business day of patient admit to KDAOS. On day 20, contact ADRC for CARE Level 1 assessment if patient stay will extend beyond Day 30.
Out of State Admissions*	Fax to KDAOS Care Staff at: 785-291-3427 or e-mail at KDAOS.CARE @ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Out of State PASRL signed and dated	Send fax within one business day of patient admit to KDAOS
Terminal Illness Admissions*	Fax to KDAOS Care Staff at: 785-291-3427 or e-mail at KDAOS.CARE@ks.gov	1. Special Admission Fax Memo 2. Physician signed order stating 6 months or less to live 3. Sections A&B of the CARE Assessment	Send fax within one business day of patient admit to KDAOS Terminal Illness Certification is good for 6 months from the date of the signed order
Request for Resident Review*	Fax KDAOS Care Staff at: 785-291-3427 or e-mail at KDAOS.CARE@ks.gov	1. Resident Review Check List 2. Release of Information form	Three weeks prior to end of previously authorized stay OR as soon as M/O/O/D is discovered Questions Contact: 785.291.8360
CARE Assessment*	Contact your local ADRC to schedule an appointment	None	On or before admission to the nursing facility, regardless of payer source.

*REGARDLESS OF PAYMENT SOURCE - One of the above types of admission paper work is REQUIRED for all residents entering a Medicaid certified nursing facility. (02/13/2018)

CLIENT ASSESSMENT, REFERRAL AND EVALUATION (CARE) INFORMATION

Expand all

Training Nursing Facility Assessors

This is the Nurse Training for the PASRR paperwork that each Medicaid licensed nursing facility is required to complete to full fill the State Statute. This training is for nursing facility assessors only. Nursing facility assessors are Licensed Social Workers, LSW, LMSW, LBSW, LGSW, LSSW, LDCS, RD, RDN, LPN or the DON.

- Nursing Facility PASRR Training

PASRR and Level I Assessor Training for ADRC / AAA and Hospital Personnel

Kansas Train has a dashboard that will give you a overview of the trainings you have taken and the status of that training, the course certificates, as well as other account information.

How To Create an Account on Kansas Train

Helpful Hints When Signing up for an Account on Kansas Train

Course Registration Instructions on Kansas Train

Launch Online Training

- Draft Policies for Review / Comment
- Informational Memos
- Final Policies
- Adult Care Homes (SCCC)
- Home and Community Based Services
- Provider Information
- Behavioral Health Services Provider
- Information
- Client Assessment, Referral and Evaluation Information**
- Statutes and Regulations
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Type of issue	What to do	Information to send	When
For Medicaid only MS-2126	FAX to KanCare at: 1-844-264-6285 Or mail: The KanCare Clearinghouse: PO Box 3599, Topeka, KS 66601	Fill out completely do not leave items blank. Use the new form MS-2126 Old forms will not be accepted after August 31, 2017	Please send form within 5 working days of the resident admit. Fill out upon admission and discharge (if discharge will be for more than 30 days.)
Emergency Admissions*	Fax local AORC and Fax to KDADS Care 785-291-1427 or e-mail KDADS.CARE@ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Order if applicable 4. APS FORM (PPS 105.10) if applicable	Send fax within one business day of admission. 7 days to complete Care Level 1 assessment.
Respite Stay*	Fax KDADS Care Staff at: 785-291-1427 or e-mail KDADS.CARE@ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Respite order signed by Physician include admit and discharge dates	Send fax within one business day of patient admit to KDADS
Less than 30 Day Admissions*	Fax to KDADS Care Staff at: 785-291-1427 or e-mail at KDADS.CARE@ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Less than 30 day order signed by hospital attending prior to admission*	Send fax within one business day of patient admit to KDADS On-day 20, contact AORC for CARE Level 1 assessment if patient stay will extend beyond Day 30.
Out of State Admissions*	Fax to KDADS Care Staff at: 785-291-1427 or e-mail at KDADS.CARE @ks.gov	1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Out of State PABH signed and dated	Send fax within one business day of patient admit to KDADS
Terminal illness Admissions*	Fax to KDADS Care Staff at: 785-291-1427 or e-mail at KDADS.CARE@ks.gov	1. Special Admission Fax Memo 2. Physician signed order stating 6 months or less to live 3. Sections A&B of the CARE Assessment	Send fax within one business day of patient admit to KDADS Terminal illness Certification is good for 6 months from the date of the signed order
Request for Resident Review*	FAX KDADS Care Staff at: 785-291-1427 or e-mail at KDADS.CARE@ks.gov	1. Resident Review Check List 2. Release of Information Form	Three weeks prior to end of previously authorized stay OR as soon as MFC/ODD is discovered Questions Contact: 785.291.3360
CARE Assessment*	Contact your local AORC to schedule an appointment	None	On or before admission to the nursing facility, regardless of payer source.

*REGARDLESS OF PAYMENT SOURCE - One of the above types of admission paper work is REQUIRED for all
residents entering a Medicaid certified nursing facility. (02/13/2018)



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..... Contact Information and Instructions

CLIENT ASSESSMENT, REFERRAL AND EVALUATION (CARE) INFORMATION

Expand all

Training

CARE Brochure

CARE Manuals

Kansas CARE Forms

- Care Level 1 - Parts A and B
- Complete Care Level 1
- Resident Review Check List
- CARE Special Admission Fax Memo
- AAA Phone List
- ID-DD-PASRR Pre-Admission Screen
- ID-DD Resident Review
- MI-PASRR Pre-Admission Screen
- MI Resident Review



Kansas CARE Program Annual Report

What is a PASRR?

PRE-ADMISSION SCREENING and RESIDENT REVIEW

To comply with Section 1919(e)(7) of the Social Security Act, every individual admitting to a Medicaid-certified nursing facility must have proof of a valid PASRR unless an exception applies. The purpose of the PASRR is to determine whether an individual with mental illness or intellectual disability requires the level of services provided by a nursing facility or specialized mental health or intellectual disability services.

What is the CARE Program?

The Client Assessment, Referral, and Evaluation (CARE) Program was developed in 1995 by the state of Kansas for data collection, individual assessment, referral to community-based services, and appropriate placement in long-term care facilities.

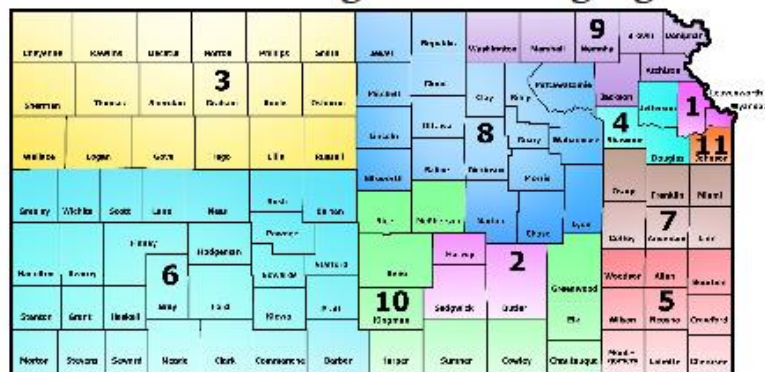
What is the Level I CARE Assessment?

- The CARE Level I assessment is two assessments in one:
 - The PASRR is the federal requirements to enter a Medicaid license nursing facility, Section B; and
 - The level of care portion of the assessments is to meet the level of care score for KanCare.
 - This score ensures that the client needs nursing facility care.
 - If the score is not above a certain level KanCare will not pay the nursing facility for their clients stay.

Level I CARE Assessment

- A complete Level I CARE assessment is required before the day of admission to any medicaid licensed nursing facility in the state of Kansas, regardless of the resident's payer source, unless a valid exception applies.
- If a resident enters the nursing facility without a valid Level I CARE assessment AND the resident does not meet the criteria for a special admission, contact the local AAA to schedule an appointment for the assessment to be performed. The AAA has 5 business days to complete the assessment.

Kansas Area Agencies on Aging



PSA 01 – Wyandotte – Leavenworth
CARE Team Lead: Jacqui Watts
 Location: 849 N. 47th, Suite C
 Kansas City KS, 66102
 Phone: 913-573-8531 Fax: 913-573-8578
 Email: care@wycokck.org

PSA 02 – Central Plains
CARE Team Lead: Monica Cissell
 Location: 271 W. Third St. N.
 Wichita, KS 67202
 Phone: 855-200-2372; Fax: 316-660-1936
 Email: mcissell@cpaaa.org

PSA 03 – Northwest Kansas
CARE Team Lead: Tammy Gerhardt
 Location: 510 W. 29th Street, Suite B
 P.O. Box 610, Hays, KS 67601-3703
 Phone: 785-628-8204/800-432-7422 Fax: 785-628-6096
 Email: nwkaaa@nwkaaa.org

PSA 04 – Jayhawk
CARE Team Lead: April Maddox
 Location: 2910 SW Topeka Blvd.
 Topeka, KS 66611
 Phone: 785-235-1367/800-798-1366 Fax: 785-235-2443
 Email: amaddox@ihawkaaa.org

PSA 05 – Southeast Kansas
CARE Team Lead: Joan Newman
 Location: 1 West Ash St.
 Chanute, KS 66720-1010
 Phone: 620-431-2980/800-794-2440 FAX: 620-431-2988
 Email: joan.newman@sekaaa.com

PSA 06 – Southwest Kansas
CARE Team Lead: Carol Harder
 Location: 236 San Jose Drive,
 Dodge City, KS 67801
 Phone: 620-225-8230 Fax: 620-225-8239
 Email: swksadrc@swksaging.org

PSA 07 – East Central Kansas
CARE Team Lead: Ginger Acker
 Location: 117 South Main,
 Ottawa, KS 66067-2327
 Phone: 785-242-7200/800-633-5621 Fax: 785-242-7202
 Email: ackadrc@eckaaa.org

PSA 08 – North Central Flint Hills
CARE Team Lead: Kelsey Pfannenstiel
 Location: 401 Houston St. Manhattan,
 KS 66502
 Phone: 785-776-9294/800-432-2703
 Fax: 785-776-9904
 Email: amandam@ncfhaaa.com;
LaurenD@ncfhaaa.com;
kelseyvp@ncfhaaa.com

PSA 09 – Northeast KS
CARE Team Lead: Karen Wilson
 Location: 1803 Oregon, Hiawatha, KS
 66434-2222
 Phone: 785-742-7152/800-883-2549
 Fax: 785-742-7154
 Email: nekaaa@nekaaa.org

PSA - 10 South Central Kansas
CARE Team Lead: Sarah Long
 Location: 304 S. Summit, Arkansas City,
 KS 67005
 Phone: 620-442-0268 Fax: 620-442-0296
 Email: sarah@sckaaa.org

PSA - 11 Johnson County
CARE Team Lead: Stacie Tripodi
 Location: 11811 S. Sunset Drive, Suite
 1300 Olathe, KS 66061-7056
 Phone: 913-715-8861; 888-214-4404
 Fax: 913-715-8825
 Email: Stacie.Tripodi@jocogov.org

Updated 08/15/2019

Certificate of CARE Assessment

This certificate is evidence of completion of a CARE assessment. Keep it with your medical records.

If you want to live in a nursing facility, you must take a copy of this certificate with you when you apply for admission. If you want to live in your home or other community-based setting, the Area Agency on Aging can help you find appropriate services.

This certificate is good for one year. If your health status or abilities change, you may request a new assessment. Should you need additional copies of this certificate or your completed two-page assessment, or want additional information, contact your Area Agency on Aging at: _____

I certify that I have completed a CARE assessment for _____

(client's name)

on _____ . The preadmission requirement found in Public Law 100-203 has been met.
(date)

The Preadmission Screening and Annual Resident Review (PASARR) portion of the assessment:

_____ did not indicate a need for further evaluation.

_____ indicated a need for further evaluation. I am referring the client to a Level II assessor.

I am referring the client to a community-based service:

_____ Area Agency on Aging _____ DCF Adult Services _____ Independent Living _____ Other _____

No referral is necessary, the client:

_____ does not need / does not wish help in finding community-based services.

_____ has selected a nursing facility.

_____ has not made final LTC decision.

(Assessor Signature)

(Assessor Number)

I hereby acknowledge that I have received a copy of the **Notice of Right to Request a Fair Hearing** attached to my copy of the Certificate of CARE Assessment.

(Client Signature)

(Date)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, Social Security Number: ____ - ____ - ____ DOB ____/____/____
Name of client (optional)

hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that signing this form is voluntary.

Providing the information: Person(s)/Organization(s) (check all that applies)

____ Community mental health center(s): *Numbers*
____ Community developmental disability organization(s): *Numbers*
____ Adult Protective Services: *Names*
____ Hospitals/nursing facility/LEO: *Names*

Other(s): name/address/phone _____

Receiving the information:

Person(s)/Organization(s) (check all that applies)

____ Area Agency on Aging:
____ *name*
____ Kansas Department for Aging and Disability Services
____ Healthsource Integrated Solutions

Other(s):

name/address/phone _____

Description of Information to be Used or Disclosed (place a check mark or an "x" next to the item(s) to be used or disclosed):

____ Recent History and Physical within the last 2 years; ____ Medical records for inpatient psych hospitalizations within the last 2 years; ____ List of dates showing increase services to a CMHC, VA, etc. for more than 30 days in the last 2 years; ____ LEO/APS/Housing Interventions/reports last 2 years; ____ IQ test or documentation including score; ____ Partial Hospitalizations or day services to CMHC, VA or the like in the last 2 years

The purpose of the Use or Disclosure: *Completion of a PASRR Evaluation and for continuum of care ***Return requested documentation to: AITN: CARE at KDADS.CARE@KS.GOV or FAX to (785)291-3427*

The Individual or the Individual's Representative must read or have the following read to them and initial by each item below:

____ (Initials) I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that the refusal to sign this authorization may mean that the use and/or disclosure described in this form will not be allowed.

____ (Initials) I understand this Release is valid for one year from today's date.

____ (Initials) I understand that I may revoke this Release at any time by notifying the providing organization in writing. It will not have an effect on actions that were taken prior to the revocation.

____ (Initials) I understand that once the uses and disclosures have been made pursuant to this authorization, the information released may be subject to re-disclosure by any recipient and will no longer be protected by federal privacy law.

____ (Initials) This will not condition treatment or payment on my providing authorization for this use or disclosure, except to the extent the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I certify that I agree to the uses and disclosures listed above and that I have received a copy of this authorization. (Form must be completed before signing).

Signature _____

Date _____

Signature of Personal Representative (if applicable) _____

Date _____

Description of Authority _____

Certificate of CARE

(Golden Ticket to the NF)

A Level 1 CARE Assessment is valid for 365 days from the date of the assessment. This means once the assessment is completed the person has 365 days to enter a NF. Once they enter, the assessment is valid until the discharge. If they discharge to their home or the community, the assessment is valid for 6 months from the date of the discharge.

Special Admissions

Every resident who enters a Medicaid-certified nursing facility, regardless of payer source, must have a Level I CARE assessment completed **BEFORE THE FIRST DAY** of admission unless a valid exception applies, including the following special admission

- An Emergency Admission
- A Respite Stay
- A Less Than 30-Day Admission
- An Out-of-State Admission
- A Terminal Illness

How to Complete Sections A and B for Nursing Facility Special Admissions

- When the resident arrives to the facility as a special admission, the nursing facility is responsible for filling out Sections A and B of the Level I CARE assessment.
(ONLY if there is NO Level I CARE Assessment)
- EVERY SINGLE special admission MUST have Sections A and B completed.
- A nursing facility may NOT complete any other sections of the assessment.
- Sections A and B may only be completed by a licensed social worker, social services designee, registered nurse, or licensed practical nurse.

How to Complete Sections A and B for Nursing Facility Special Admissions

- Sections A and B must be completed UPON ADMISSION of the resident being admitted to the facility. Within the first 24 hours of admission.
- Every time a resident is admitted to a nursing facility without a valid Level I CARE assessment, the nursing facility must have a valid special admission order. Each new admission gets its own Section A and B.

A. IDENTIFICATION**1. Social Security # (Optional)**

2. Customer Last Name

First Name _____ **MI** _____**3. Customer Address**

Street _____

City _____ County _____

State _____ Zip _____

Phone _____

4. Date Of Birth ____/____/____**5. Gender** ☐ Male ☐ Female**6. Date of Assessment** ____/____/____**7. Assessor's Name**

8. Assessment Location

9. Primary Language☐ Arabic ☐ Chinese ☐ English☐ French ☐ German ☐ Hindi☐ Pilipino ☐ Spanish ☐ Tagalog☐ Urdu ☐ Vietnamese☐ Sign Language ☐ Other _____**10. Ethnic Background**☐ Hispanic or Latino☐ Non Hispanic or Latino**11. Race**☐ American Indian or Alaskan Native☐ Asian☐ Black or African American☐ Native Hawaiian, or Other Pacific Islander☐ White☐ Other _____☐ Other _____**12. Contact Person Information**

Name _____

Street _____

City _____

State _____ Zip _____

Phone _____

Guardian ☐ Yes ☐ No**B. PASRR****1. Is the customer considering placement in a nursing facility?** ☐ Yes ☐ No**2. Has the customer been diagnosed as having a serious mental disorder?**☐ Yes ☐ No**3. What psychiatric treatment has the customer received in the past 2 years (check all that apply)?**☐ 2 Partial hospitalizations☐ 2 Inpatient hospitalizations☐ 1 Inpatient & 1 Partial hospitalization☐ Supportive Services☐ Intervention☐ None

For those individuals who have a mental diagnosis and treatment history please record that information _____

4. Level Of Impairment?☐ Interpersonal Functioning☐ Concentration/ persistence/ and pace☐ Adaptation to change☐ None**5. Has the customer been diagnosed with one of the following conditions prior to age 18 for Mental Retardation / Developmental Disability, or age 22 for related condition, and the condition is likely to continue indefinitely?**☐ Developmental Disability (IQ _____)☐ Related Condition☐ None

For those individuals who have a development disability or related condition please record that information: _____

6. Referred for a Level II assessment?☐ Yes ☐ No**C. SUPPORTS****1. Live alone** ☐ Yes ☐ No**2. Informal Supports available**☐ Yes ☐ Inadequate ☐ No**3. Formal Supports available**☐ Yes ☐ Inadequate ☐ No**D. COGNITION****1. Comatose, persistent vegetative state** ☐ Yes ☐ No**2. Memory, recall**☐ Orientation☐ 3-Word Recall☐ Spelling☐ Clock Draw**E. COMMUNICATION****1. Expresses information content, however able**☐ Understandable☐ Usually understandable☐ Sometimes understandable☐ Rarely or never understandable**2. Ability to understand others, verbal information, however able**☐ Understands☐ Usually understands☐ Sometimes understands☐ Rarely or never understands**F. RECENT PROBLEMS / RISKS**☐ Falls (6 mo) ☐ Falls (1 mo)☐ Injured head during fall(s)☐ Neglect/ Abuse/ Exploitation☐ Wandering☐ Socially inappropriate/ disruptive behavior☐ Decision Making☐ Unwilling/Unable to comply with recommended treatment☐ Over the last few weeks / months - experienced anxiety / depression.☐ Over the last few weeks/ months - experienced feeling worthless☐ None**G. CUSTOMER CHOICE FOR LTC**☐ Home without services☐ Home with services☐ ALF/ Residential/ Boarding Care☐ Nursing Facility (name below): _____☐ Anticipated less than 90 days

Street _____

City _____ Zip _____

Phone _____

Section A

Resident Identification

- Question 1: A social security number is the best way to identify the resident. Some residents across the state may have the same name and/or date of birth.
 - The social security number ID is optional.
 - Leave this section blank if you do not have verified proof of the social security number.
 - Please do not use a Medicaid ID in place of the SSN. The Medicaid ID may belong to the resident's spouse.

Section A

Resident Identification

- Question 2: Please list the resident's legal first name and last name. If the resident goes by another name, please add it in parentheses next to the resident's legal name.
- Question 3: Please list the resident's last known residential address.
 - If the resident is homeless, please only fill out the information for the nursing facility's address. On the line labeled "Street Address," please write "HOMELESS."
 - If the resident's last address is unknown, please only fill out the information for the nursing facility's address. On the line labeled "Street Address," write "UNKNOWN."

Section A

Resident Identification

- Question 4: Enter the resident's date of birth.
- Question 5: Enter the resident's gender.
- Question 6: Enter the date that the form was completed, which should be the date the resident was admitted to the facility.
- Question 7: Please legibly print the name and job title of the person completing the form.

Section A

Resident Identification

- Question 8: Please write out the entire name of the nursing facility. Do not abbreviate the name.
 - For example, if the resident is being admitted to a nursing facility owned by a corporation that operates more than one nursing facility in the state, please add the location of the facility to the name. (e.g., “Diversicare of Chanute;” “Medicalodges Coffeyville”)
- Questions 9 – 11: Please answer all of these questions completely. Do not leave any items blank.
 - Question 9: Check the box of the primary language the resident understands.
 - Question 10: Check the box that the resident considers as his or her ethnicity.
 - Question 11: Check the boxes that the resident considers as his or her race.

Section A

Resident Identification

- Question 12: Please list the name, address, and phone number for the resident's emergency contact person. If the resident has a guardian or DPOA that is activated, list that person first. If the resident does not have a guardian or active DPOA, list the resident's primary caregiver.
 - If the emergency contact is also the resident's DPOA, write "DPOA" next to the emergency contact's name
 - Please check the box indicating whether the emergency contact is the resident's legal guardian
 - If there is not an emergency contact, write "NO CONTACT" on the line titled "Name"
- KDADS may refuse to accept forms that leave Question 12 blank or indicate "self" as the resident's emergency contact person.

Section B

PASRR

- Question 1: Check “YES” if the resident or responsible person is requesting nursing facility placement
 - If you are considering that someone in your facility may now be a level II PASRR person, these are ALL the same requirements
- Question 2: Has the customer been diagnosed as having a serious mental disorder? You can verify this information with:
 - the resident;
 - the resident’s family, legal guardian, DPOA, or physician; or
 - the resident’s medical record

Section B

MUST have a diagnosis

- 295.70 (F25.0) Schizoaffective Disorder, Bipolar Type
- (F35.1) Schizoaffective Disorder, Depressive type
- 295.90 (F20.9) Schizophrenia
- 296.34 (F33.3) Major Depressive Disorder, Recurrent, Severe, with Psychotic Features
- 296.44 (F31.2) Bipolar I disorder, most recent episode (or current) manic, severe, specified as with psychotic behavior
- 296.54 (F31.5) Bipolar I disorder, most recent episode (or current) depressed, specified as with psychotic behavior
- 298.9 (F28) Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- 296.23 (F32.2) Major Depressive Disorder, Single Episode, Severe
- 296.24 (F32.3) Major Depressive Disorder, Single Episode, With Psychotic Features
- 296.32 (F33.1) Major Depressive Disorder, Recurrent Moderate
- 296.43 (F33.2) Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
- 296.35 (F33.41) Major Depressive Disorder, Recurrent, In Partial Remission
- 296.89 (F31.81) Bipolar II Disorder
- 297.10 (F22) Delusional Disorder
- 300.01 (F41.0) Panic Disorder
- 300.22 (F40.00) Agoraphobia
- 300.3 (F42) Obsessive-Compulsive Disorder
- 300.3 (F42) Hoarding Disorder
- 301.83 (F60.3) Borderline Personality Disorder
- 309.81 (F43.10) Posttraumatic Stress Disorder

Section B

Treatment History

- Question 3: Check the appropriate boxes indicating what, if any, psychiatric treatment the resident has received in the past two years.
 - 2 Partial Hospitalizations: The customer participated more than one (1) day in a program offered by mental health entity, which included therapies and services during the daytime.

OR

- 2 inpatient hospitalizations: The customer had two (2) or more hospitalizations in a psychiatric hospital or in a psychiatric unit of a hospital, and the hospital stays were for 24 hours or more. A stay in a state hospital for two (2) or more consecutive years count as two (2) inpatient hospitalizations.

Section B

Treatment History

OR

- 1 inpatient and 1 Partial: The customer had at least one (1) Inpatient and one (1) Partial hospitalization.

OR

- Supportive Services: Has the customer received support services that significantly increased for a period of 30 consecutive days or longer in the last two years that were provided by a Community Mental Health Center (CMHC), the Veterans Affairs (VA) Hospital, or a correctional facility?

Section B

Treatment History

OR

- Intervention: Housing—When the individual has been evicted (including from a shelter) for situations which include:
 - Inappropriate social behavior (*i.e.*, screaming, verbal harassment of others, physical violence toward others, inappropriate sexual behavior and etc.); and
 - Abuse or neglect of physical property (*i.e.*, failure to maintain property as outlined in the lease, intentional destruction of property such as through kicking or hitting walls or doors, etc.).
- Note: Nonpayment of rent, substance abuse, and other such situations can only be included in this category if a direct relationship between the activity and an increase in the severity of the mental illness can be shown

Section B

Treatment History

- Law enforcement officials- When the individual has been arrested and/or taken into custody due to:
 - Harm to self, or property; inappropriate social behavior (*i.e.*, screaming, verbal harassment of others, physical violence toward others, inappropriate sexual behavior, etc.); or
 - Evidence of impairment so severe as to require monitoring for safety.
- Note: Substance abuse can only be included in this category if a direct relationship between the activity and an increase in the severity of the mental illness can be shown.
- Adult protective services (APS)- When the individual has been determined by an APS worker to be a danger to self or others due to the severity of the mental illness. For example, the individual threatens harm to self or others, is not eating, exhibits extreme weight loss or is non-compliant with medications.

Section B

Level of impairment

- Question 4: Check the box if the resident or responsible party reports the resident has experienced a level of impairment in that category within the last 3-6 months due to mental illness. See the CARE Manual for more information about how to answer questions regarding the resident's level of impairment.

Section B

Level of impairment

- Interpersonal Functioning
 - The customer has serious difficulty interacting appropriately and communicating effectively with other persons. There may be a history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation.
- Concentration/ Persistence/ Pace
 - The customer has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in structured activities occurring in the school or home. The customer has difficulties in concentration, an inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.

Section B

Level of impairment

- Adaptation to Change
 - The individual has serious difficulty adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system

Section B

Intellectual and Developmental Disabilities and Related Condition

- Question 5: Please check the box indicating whether the resident has been diagnosed with an intellectual or developmental disability, a related condition, or neither.
 - See the CARE Manual for more information about what qualifies as a intellectual/developmental disability or a related condition
- An intellectual/developmental disability is defined as significantly sub-average intellectual functioning as evidenced by an IQ score of 70 or below on standardized measure of intelligence prior to the age of 18.
- For individuals with an intellectual or developmental disability, please enter the following information:
 - IQ score and date of testing: If you have a valid score, please enter it on the form and attach the supporting documentation. If you do not have a valid score with supporting documentation, leave the score blank; AND
 - Developmental disability diagnosis: Enter the diagnosis on the line provided

Section B

PASRR

- A related condition is defined as a condition such as autism, cerebral palsy, epilepsy, Spina Bifida, Down's Syndrome, or another physical and/or mental impairment that is:
 - Evidenced by a severe, chronic disability;
 - Manifested before the age of 22;
 - Will likely continue indefinitely;
 - Reflects a need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated; and
 - Results in substantial functional limitations in three or more major life activities.
- For individuals who have a related condition, please record the related condition diagnosis on the line provided.

Section B

PASRR

- Question 6: Check the appropriate box indicating whether the resident requires a Level II assessment. YES or NO
 - An individual with a Serious Mental Illness must be referred for a Level II Assessment if:
 - The individual has a documented clinical diagnosis of a serious mental illness as described in the CARE Manual; And
 - The individual has a level of impairment due to the mental illness that impacted major life activities within the past 3-6 months; AND
 - Within the past two years, the individual:
 - Had 2 or more inpatient or partial psychiatric hospitalizations; OR
 - Received supportive services at least 30 consecutive days; OR
 - Required intervention by housing officials, law enforcement, or APS because of a situation caused by the mental illness

If all of the above the answer is YES, if not all of the above the answer is NO.

Section B

PASRR

Question 6: Check the appropriate box indicating whether the resident requires a Level II assessment. YES or NO

- An individual with an intellectual or developmental disability must be referred for a Level II Assessment if the individual has:
 - A documented IQ of 70 or below; AND
 - Manifested before the age of 18

OR

- An individual with a related condition must be referred for a Level II Assessment if the related condition:
 - Manifested before the age of 22;
 - Will likely continue indefinitely; AND
 - Impacts 3 or more major life activities

If IQ score, diagnosis and proof before age 18 or diagnosis and proof before age 22: YES

If no score or proof before age 18 or no diagnosis and proof before age 22: NO

Quick Fax Sheet

QUESTIONS REGARDING THE CARE PROCESS:
CALL 785.296.6446

Type of issue	What to do	Information to send	When
For Medicaid only MS-2126	FAX to KanCare at: 1-844-264-6285 Or mail: The KanCare Clearinghouse; PO Box 3599; Topeka, KS 66601	Fill out completely do not leave items blank. Use the new form MS-2126 Old forms will not be accepted after August 31, 2017	Please send form within 5 working days of the resident Admit. Fill out upon admission and discharge (If discharge will be for more than 30 days.)
Emergency Admissions*	Fax local ADRC and Fax to KDADS Care 785-291-3427 or e-mail KDADS.CARE@ks.gov	<ol style="list-style-type: none"> 1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Order if applicable 4. APS FORM (PPS 10510) if applicable 	Send fax within one business day of admission. 7 days to complete Care Level 1 assessment.
Respite Stay*	Fax KDADS Care Staff at: 785-291-3427 or e-mail KDADS.CARE@ks.gov	<ol style="list-style-type: none"> 1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Respite order signed by Physician include admit and discharge dates 	Send fax within one business day of patient admit to KDADS
Less than 30 Day Admissions*	Fax to KDADS CARE Staff at: 785-291-3427 or e-mail at KDADS.CARE@ks.gov	<ol style="list-style-type: none"> 1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Less than 30 day order signed by hospital attending prior to admission* 	Send fax within one business day of patient admit to KDADS On day 20, contact ADRC for CARE Level 1 assessment if patient stay will extend beyond Day 30.
Out of State Admissions*	Fax to KDADS CARE Staff at: 785-291-3427 or e-mail at KDADS.CARE@ks.gov	<ol style="list-style-type: none"> 1. Special Admission Fax Memo 2. Sections A & B of CARE Assessment 3. Out of State PASRR signed and dated 	Send fax within one business day of patient admit to KDADS
Terminal Illness Admissions*	Fax to KDADS CARE Staff at: 785-291-3427 or e-mail at KDADS.CARE@ks.gov	<ol style="list-style-type: none"> 1. Special Admission Fax Memo 2. Physician signed order stating 6 months or less to live 3. Sections A&B of the CARE Assessment 	Send fax within one business day of patient admit to KDADS Terminal Illness Certification is good for 6 months from the date of the signed order
Request for Resident Review*	FAX KDADS CARE Staff at: 785-291-3427 or e-mail at KDADS.CARE@ks.gov	<ol style="list-style-type: none"> 1. Resident Review Check List 2. Release of Information Form 	Three weeks prior to end of previously authorized stay <u>OR</u> as soon as MI/ID/DD is discovered Questions Contact: 785.291.3360
CARE Assessment*	Contact your local ADRC to schedule an appointment	None	On or before admission to the nursing facility, regardless of payer source.

***REGARDLESS OF PAYMENT SOURCE - One of the above types of admission paper work is REQUIRED for all residents entering a Medicaid certified nursing facility (02/13/2018)**

Emergency Admission

Definition:

- Emergency admissions are when the individual is admitted to a nursing facility or long-term care unit due to an emergency that places the individual's health and/or welfare in jeopardy.
- Emergency admissions must fit under one of the criteria established by KDADS policy.

Emergency Admission

KDADS Criteria

- 1) An admission is requested by Adult Protective Services (APS) at the Department for Children and Families (DCF);
- 2) A natural disaster occurs that substantially impacts the individual's current living situation;
- 3) The individual's primary caregiver becomes unavailable due to a situation beyond the caregiver's control (e.g., the caregiver dies or becomes seriously ill or injured);
- 4) A physician orders an immediate admission due to the individual's health condition; or
- 5) The individual is admitted to the nursing facility from an out-of-state community due to circumstances beyond the individual's control (Ex: admitted from the individual's place of residence in another state on a weekend when an AAA Level I CARE assessor is not immediately available).



KDADS CARE Special Admission Fax Memo

CONFIDENTIAL

Client Name _____

Admission Date to Nursing Facility _____ # of pages _____

From/Title _____

Nursing Facility Name _____

Nursing Facility Address _____

Phone/e-mail _____

Please attach Sections A&B of the level 1 CARE assessment with each Special Admission. Please select the admission type below.



#1 – Emergency Admission

Check the reason for the Emergency:

- ☐ 1 An admission is requested by Department for Children and Families (DCF) Adult Protective Services (APS);
- ☐ 2 A natural disaster has occurred that substantially impacts the individual's current living situation;
- ☐ 3 The individual's primary caregiver is unavailable, due to circumstances beyond the caregiver's control (e.g., caregiver dies, becomes ill or is injured);
- ☐ 4 A physician-ordered immediate admission due to the individual's condition; or
- ☐ 5 The admission to the nursing facility is from an out-of-state community due to circumstances beyond the individual's control, (e.g., admitted from the individual's place of residence in another state on a weekend when an ADRC CARE assessor is not available).

Please send the APS (PPS 10510) form if selecting reason 1, and the physician-signed orders if selecting reason 4.

Emergency Admission

The doctors note and APS document

- If a physician orders an emergency admission due to the individual's health condition, it must be sent to KDADS.
 - Please Note: Verbal/Telephone are not valid for PASRR, all signatures must be wet or electronic signature. We do NOT accept verbal orders.
- A nursing facility's personal Medical Director or physician may not write an emergency admission order to the nursing facility. All orders must be written outside the facility, showing they are being admitted to the facility. If your medical director is also the person's primary care physician, the order must come from their clinic.
- If APS requested the emergency admission, the nursing facility must fax DCF form PPS 10510 to the KDADS CARE Program along with the KDADS Special Admission Fax Memo.

Emergency Admission

What to send to KDADS

Fax to 785-291-3427 or Email to KDADS.CARE@ks.gov

- A completed KDADS Special Admission Fax Memo
- A completed Section A&B
- If applicable a doctors note, stating that it is an emergency admission or if applicable the PPS 10510 from APS

****ALSO contact your local AAA upon admission, because an emergency admission is only valid for 7 days. The CARE Level I must be completed before day 7 of the admission. ****

Less than 30-Day Special Admission

Definition

The Less Than 30-Day special admission is an admission to a nursing facility that is anticipated to last less than 30 days following an inpatient medical hospital stay. The order must come from the medical hospital signed by the individual's attending physician who certifies that the individual is likely to require less than 30 days of nursing facility services.

Less than 30-Day Special Admission

Less than 30 day order

Before the resident is admitted, the nursing facility must verify that the less than 30-day order meets the following guidelines:

- The order **MUST** be on the discharge paperwork from the hospital sending the individual;
- The order **MUST** state that the individual's anticipated nursing facility stay is less than 30 days; and
- The order **MUST** be signed and dated by the hospital attending physician.
 - **Please Note: Verbal/telephone orders are not accepted**
 - Only wet or electronic signatures are allowed.
- **Orders from MENTAL HOSPITALS OR BEHAVIORAL UNITS ARE NOT ALLOWED!**

Only orders that meet the guidelines will be accepted; no other orders will be considered valid.

Less than 30-Day Special Admission

Less than 30 day order

- If “less than 30 day stay” is written on the discharge order after the physician signs the order, the physician is required to initial or sign next to the handwritten language.
 - The KDADS CARE Program will not accept orders that have been amended without the physician's signature/initials next to the handwritten change.

Less than 30-Day Special Admission

What to send to KDADS

Fax to 785-291-3427 or Email to KDADS.CARE@ks.gov

- A completed KDADS Special Admission Fax Memo
- A completed Section A&B
- A signed and dated less than 30-day order

Less than 30-day Special Admission

- IF the person is going to stay in your nursing facility past day the 30 days from the date of the signed order, you will need to contact your local AAA to get a level I assessment completed. Please contact them, by day 20 of the 30 day stay so they have time to complete the level I before the 30 days end.
- IF the person is going to discharge at any time before day 30 of the stay, you do not need to contact the AAA for the level I.
- IF you accept someone for admission in the middle of a 30 day stay, please verify what day they are on, because it is only valid for 30 days from the date it is signed.

Out-of-State Admissions

Definition:

- An out-of-state admission occurs when a resident is admitted to a Kansas nursing facility from an out-of-state nursing facility or hospital.
- If the resident has a valid less than 30-day order from an out-of-state hospital, the nursing facility does not need the out-of-state PASRR (follow the directions a for less than 30-day admission)

Out-of-State Admissions

When to contact the Area Agency on Aging:

- The nursing facility does not need to contact the local AAA for a Level I CARE assessment.
 - If the resident discharges from the nursing facility and returns to the community for more than 30 days, a new Level I CARE assessment will be required upon readmission.
 - If the out of state PASRR is a LEVEL II out of state PASRR, the nursing facility DOES have to contact the AAA and get a new level I to see if they qualify for a Kansas Level II
- A valid out-of-state PASRR fulfills the requirements of a Level I CARE assessment.

Out-of-State Admissions

What to send to KDADS:

Fax to 785-291-3427 or Email to KDADS.CARE@ks.gov

- A completed KDADS Special Admission Fax Memo
- A completed Section A&B
- A completed, signed and dated PASRR from the state they are admitting from.

Respite

Definition:

- A respite stay is a physician-ordered short-term stay in a nursing facility with defined admission and discharge dates. Respite care may be provided to residents on an intermittent basis for period of fewer than 30 days at any one time without a Level I CARE assessment in line with the requirements of the CARE Manual.
- Hospice Respites are allowed a total of 5 days at a time.

Respite

The Respite Order

- Before the resident is admitted, the nursing facility must verify that the respite order meets the following guidelines:
 - The order must be signed and dated by the physician sending the resident for the respite stay; and
 - The order must include a planned admission date and a planned discharge date.
- *Please note: Verbal/Telephone orders are not accepted. The orders must be signed wet or electronically by the physician.**
- A nursing facility's Medical Director or physician may not write an admission order to the facility. If the nursing facility's Medical Director or physician is also the resident's primary care physician, the physician's order must come from the physician's office.

Respite

When to contact the Area Agency on Aging

When or if the resident stays longer than the planned date of discharge here are the nursing facility options:

- A new order with the extended days must be sent to the KDADS CARE program, but the order can't exceed a total of 30 days from the date of admission;
- A Level I CARE assessment must be completed on or before the last day of the respite stay order signed by the physician.
- The facility should call the Area Agency on Aging and request the level I as soon as they know the resident plans to stay permanently in the nursing facility past the allowed 30 days.

Respite

What to send to KDADS:

Fax to 785-291-3427 or Email to KDADS.CARE@ks.gov

- A completed KDADS Special Admission Fax Memo
- A completed Section A&B
- The admitting order for the Respite signed and dated by the physician.

Terminal Illness Admissions

Definition:

- A terminal illness admission occurs when a resident is admitted to a nursing facility on Hospice, end of life care, palliative care, or otherwise due to a documented terminal illness.
- A terminal illness admission is different than an admission for a Hospice respite stay.
 - If the resident is a hospice respite please follow the respite stay instructions.
 - If the resident is admitted for a Hospice respite stay, but then stays longer than 5 days, please send the Terminal Illness information by the 6th day of admission to get the Terminal Illness letter.



#2 – Respite Stay

Respite Stay is a planned, short-term stay for fewer than 30 days. Please include orders signed by a physician. The orders should include planned date of admission and planned date of discharge.



#3 – Less than 30-day Admission

Please send the less than 30-day order from the hospital signed by the attending physician. Orders must come from the hospital sending the individual.

On day 20 from the date of the signed order, if the individual is still in the nursing facility and it does not appear they will be leaving at the end of the 30 days, please contact the ADRC/AAA and have a CARE Assessment completed.



#4 – Out-of-State Admission

Please send the out-of-state PASRR for the admission. The Out-of-state PASRR must be complete, signed, and dated.



#5 – Terminal Illness



Certification

- Please send the physician-signed order stating the resident has six months or fewer to live.



Re-Certification date: _____

- Please send a NEW physician-signed order stating the resident has six months or fewer to live.
- Please send original Section A&B of the Level 1 CARE assessment

*request a Level 1 if the client is in your facility at the end of the Re-Cert (12 months)

Terminal Illness Admission

Certification and Recertification

Initial Certification:

- The initial Certification is valid for 6 months from the date of the signed order.

Recertification:

- The recertification will be valid for an additional 6 months from the date of the NEW signed order.

After 12 months total in the facility OR after the first 6 months certification, the Nursing Facility will need to call the Area Agency on Aging to get a CARE Level I.

Commission on Aging
New England Building
503 South Kansas Avenue
Topeka, KS 66603-3404



Phone: (785) 296-4986
Fax: (785) 296-0256
wwwmail@kdads.ks.gov
www.kdads.ks.gov

Timothy Kock, Secretary
Craig Kabertine, Commissioner

Jeff Colyer, M.D., Governor

Terminal Illness Certification

December 21, 2017

Jane Doe
c/o Nursing Facility
323 Somewhere in Kansas
Smallville, KS 67140

Dear Ms. Doe :

Recently you expressed an interest in admission to a Kansas nursing facility.

A review of the information provided to us at the time of the referral, including a certification of terminal illness by your physician, indicates that your medical condition does not require you to participate in the CARE assessment process at this time. You may be admitted to a nursing facility, if you (and your legal guardian, if appointed) choose admission to such setting for your long-term care. If you are admitted to a nursing facility, the PASRR must be completed.

Please keep this letter with your important medical papers, as you will be asked to present it should you choose to enter a nursing facility. **This certification is valid for 6 months from the date at the top of the letter.** You must complete the terminal illness recertification process prior to the expiration of this certification if you choose to remain in a nursing facility longer than 6 months from the date at the top of this letter.

If you have any questions about how this letter affects you, please contact Dawne Stevenson, CARE Program Manager at the Kansas Department for Aging and Disability Services, Commission on Aging. The toll-free number is 785-368-7323

Thank you for your cooperation. Our best wishes to you as you make your long term care decisions. Please let us know if we can be of any further assistance.

Sincerely,

Dawne Stevenson
CARE Program Manager

c: Nursing Facility, Social Services

Terminal Illness Admission

What to send to KDADS:

Fax to 785-291-3427 or Email to KDADS.CARE@ks.gov

Initial Certification:

- The nursing facility will send in the KDAS Fax Memo, The Sections A&B of the CARE Level I
- The order signed and dated by the physician.
- Once received KDADS will draft a Terminal Illness letter and send to the nursing facilities.

Recertification:

- The nursing facility will send in the KDADS Fax Memo;
- Original Sections A&B (unless new to your facility, then new A&B will be needed completed at admission)
- The NEW order signed and dated by the physician.
- Once received KDADS will draft a Terminal Illness letter and send to the nursing facilities.

The 2126 Form

How this works with PASRR

- The nursing facility is responsible for completing the 2126 form and sending it to the KanCare Clearinghouse. For all Medicaid Residents. Within the first 5 days of admission.
- KanCare changes KMAP from this information on the 2126.
- The KanCare Clearinghouse then sends a request to the KDADS CARE program for the dates and scores for PASRR and the Level I CARE Assessment.
- KDADS CARE Program returns the information to KanCare (if we have it)
- KanCare makes the medicaid payment to the facility based on the dates and scores the CARE program sends back.
- KanCare will NOT make a payment to the nursing facility if the PASRR is delayed or not completed or if the score is not high enough.

The 2126 Form

Additional Information

- Once a person discharges from the nursing facility, it is the nursing facilities responsibility to complete and send in the 2126 form to the KanCare clearinghouse.
- Not sending this in on time can cause delays for the next facility or home and community based services from making payments for the residents current location.
- If you get a letter from KanCare or there is an issue with the score, please contact the KDADS care program for more information.

How to contact the KDADS CARE Team

Keep in mind we are working remote.

- CARE Program Manager: Work Cell #785-506-9609 kdads.care@ks.gov
- CARE II Nurse: kdads.care@ks.gov
- Level II CARE Specialist: kdads.care@ks.gov
- CARE Specialist kdads.care@ks.gov
- CARE Specialist kdads.care@ks.gov

KDADS CARE Program FAX: 785-291-3427

Questions